Adult Volunteer Staff's Health Record

IMPORTANT: This form must be filled out completely, signed and returned with the completed application.

_____

Last Name First Name Middle Nickname

_____

Street Address City State Zip

Date of Birth:_____ Age:_____ Gender: Male or Female

Person to contact in case of emergency:

_____

Last Name First Name Middle Relationship

_____

Street Address City State Zip

Emergency Telephone Number(s): Day ( ) _____ Evening ( )_____

HEALTH HISTORY: **All questions MUST BE ANSWERED.**

Are you in good health? Yes ____ No ____

Is your Tetanus Vaccination Current? Yes ____ No ____

Do you suffer from allergies or require any medication(s): Yes _____ No _____

If yes, please state type of **allergies**: list all **medication(s)**:

Please include name of medication and time to administer.

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Prescribing Physician:_____

Name Address Telephone Number

Do you suffer from injury or condition? Yes ____ No ____ (check one)

If yes, please indicate injury or condition:

_____

Treating Physician:

_____

Name Address Telephone Number

Is there any known physical disorder that might handicap you while participating as a Volunteer Counselor in the Youth Camp? Yes ____ No ____ (check one)

If yes, please list:

_____

*** The Indiana National Guard or the Family Programs office will not be responsible for medical bills incurred by volunteers.

SIGNATURE: _____

DATE:_____